Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of Inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 14, 15, 16, 19, 20, 21, 22, 26, 27, 28, Apr 11, 12, 16, 18, 19, May 2, 3, 4, 8, 10, 2012	2012_070141_0002	Complaint

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

THE BRANT CENTRE
1182 NORTHSHORE BLVD. EAST, BURLINGTON, ON, L7S-1C5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHARLEE MCNALLY (141), ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (acting), the Assistant Director of Nursing (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietitian, Food Service Supervisor, physicians, and Social Worker

During the course of the inspection, the inspector(s) reviewed resident's records, licensee policy and procedures, home's complaint log and records of communication with family, and Family Council minutes

Log # H-000050-12, H-000144-12

PLEASE NOTE: Inspections #2012-070141-0003, 2012-070141-0004 and 2012-070141-0006 were conducted concurrently with this inspection.
Findings of non-compliance related to LTCHA s.6(10)(b) related to inspection 2012-070141-003, 2012-070141-004 and 2012-070141-006, and O.Reg79/10 s.30(2) related to inspection 2012-070141-0006 are contained in this Report of inspection.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Nutrition and Hydration

Pain

Personal Support Services

Reporting and Complaints

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care that sets out the planned care for an identified resident. The resident exhibited responsive behaviours. Staff confirmed care had to be provided for the exhibited behaviours. The written plan of care did not include directions related to the behaviours. s.6.(1)(c)
The written plan of care did not include the resident's risk related to identified diagnosis. s.6.(1)(a)

2. The licensee did not ensure staff and others collaborated with each other in the assessment of an identified resident so their assessments were integrated, consistent with and complement each other. The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) quarterly assessment was completed in 2011. The Resident Assessment Protocol (RAP) for dehydration, completed by Registered Nursing staff indicated the resident was at risk of dehydration. The documented RAP summary for the risk stated it will be care planned with goal of maintaining good hydration. The risk was not included in the resident's plan of care. The dietitian assessment completed in 2011, specified the resident meets the minimum requirement of fluid intake. Interview with the home dietitian indicated the resident was not identified at risk for dehydration. This was contrary to and not consistent with the assessment completed by registered nursing staff. s.6(4)(a)159)

3. The licensee did not ensure an identified resident's written plan of care was reviewed and revised when the resident's care needs changed. The resident was identified as requiring a change in care provided. The written plan of care was not revised to include physician instructions for monitoring and interventions related to the change in care needs. s.6(10)(b)(141)

4. The licensee did not ensure an identified resident's written plan of care was reviewed and revised when there was a change in the resident's care needs. In 2011 the attending physician had written a note for the resident related to intake. A review of the resident's clinical record and interview with the resident's attending physician confirmed the resident had a written physician order in 2012, providing further direction related to intake. The orders were not care planned to direct staff in the provision of care and the plan of care did not reflect changes in the resident's care needs. A review of the food and fluid intake record and the multidisciplinary progress notes for 2012 identified the resident had a change in intake due to a change in resident status. This change was not identified in the plan of care. i.e. oral nutritional intake. s.6(10)(b) (159)

5.The licensee did not ensure an identified resident's written plan of care was reviewed and revised when the resident care needs changed. A new Resident Assessment Protocol (RAPs) in 2012 identified the resident had exhibited responsive behaviours during the observation period. The RAP stated the plan of care would be updated to reflect the current behaviour symptoms and needs. Nursing staff confirmed the resident exhibited the identified responsive behaviours. The written plan of care did not identify resident's behavioural symptoms and did not identify interventions to direct staff in caring for the resident during exhibited behaviours. s.6(10)(b)
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012-040171-0004)

6a.The licensee did not ensure an identified resident's plan of care was reviewed and revised when the resident's care needs changed. The resident was identified as exhibiting pain in 2011 and pain medication was administered as needed. Documentation identified the resident continued to exhibit pain on an ongoing basis. Nursing staff confirmed the resident exhibited pain. The written plan of care was not revised at the time of change in pain to include resident's comfort needs with interventions to meet these needs.
b. The licensee did not ensure an identified resident's written plan of care was reviewed and revised when the resident care needs changed. The resident was identified as having a change in care needs related to change in medical status in 2011. The written plan of care was not revised to include changes in the resident care needs including comfort, mobility, intake, output, and monitoring needs. s.6(10(b)
(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012-040171-0003)

7. The licensee did not ensure the plan of care for an identified resident was reviewed and revised at a time when the resident's care needs changed. The resident stated a PSW entered their room and attempted to provide care that was not consistent with the resident's care needs. The resident reported the incident to the RPN in charge, who informed the resident that the PSW was new and did not know the resident care needs. The RPN did not document the alleged incident, assess the resident for care need changes, or communicate the incident to other staff of the home. The resident's family notified evening RPN of the incident, the resident's response, and was asked to communicate to the

night shift the event, and provide direction to staff related to the resident care needs. The evening RPN confirmed they were aware of the direction but did not document the information received, assess the resident for care need changes, or communicate to the night shift the incident that had occurred. Night staff confirmed they were not informed of the incident, or was it documented. The progress note on the night shift confirmed the staff were unaware of the incident. s.6.(10)(b)
(PLEASE NOTE: This evidence of non-compliance was found during Inspection #2012-070141-0006)(141)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to an identified resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. The resident's Substitute Decision Maker (SDM) verbalized a request for increased care related to a responsive behaviour of the resident. Documentation in the resident's progress notes stated that nursing staff were instructed to ensure the care was completed following a specified frequency. Staff confirmed the care was provided as required and the care provided was monitored. The Daily Flow Sheets for the resident were not consistent in documenting that the care was provided. s.30(2)
2. The licensee did not ensure that any actions taken with respect to an identified resident under a program, including assessment, reassessments, interventions and the resident's responses to the interventions were documented. The resident was ordered a treatment to be administered by registered staff and recorded on the Medication Administration Records (MARs). Registered staff confirmed their responsibility for administration of the treatment. The treatments were not signed by registered staff as being administered on multiple occasions to indicate the treatments had been completed. s.30(2)
3. The licensee did not ensure that any actions taken with respect to an identified resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. The resident was ordered treatments to be completed by registered staff and recorded on the Medication/Treatment Administration Records (MARs). The MARs were not signed consistently by the registered staff to indicate that the treatments were completed as ordered. The Administrator (Acting) confirmed treatments completed by registered staff must be signed in the appropriated section of the MARs.

(PLEASE NOTE: This evidence of non-compliance was found during Inspection # 2012-040171-0003)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee did not ensure that a registered dietitian who is a member of the staff of the home completed a nutritional assessment for an identified resident when there was a significant change in the resident's health status. The quarterly nutritional assessment for the resident documented in the Multidisciplinary progress notes in 2011, was not completed by the registered dietitian. A review of the resident's food and fluid intake records for multiple months identified the resident was refusing the supper meal most days and evening nourishment, special snacks and fluids every day. The licensee policy (Policy No. HHS-X-10) for quarterly nutrition assessment states to include Estimated Nutritional Requirement. The quarterly nutritional assessment documented in the electronic multidisciplinary notes in 2011, did not include evaluation of food intake and estimated nutritional requirement for the resident (an estimation of calorie and protein and micro-nutrient needs for the resident). s.26(4)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records
Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure the plan, policy, protocol, procedure, strategy or system related to documentation of food and fluid intake was complied with in respect to an identified resident. The home's policy "Daily Food and Fluid Intake Record" (NHS-X-16) stated that daily recording of food and fluid will be completed by the PSW after each meal and snack time.
The food and fluid intake record of the resident was found to be incomplete/inaccurate. Documentation regarding food and fluid intake had not been completed consistently for multiple months.
Staff confirmed that the food and fluid intake record was not completed as per the home's policy. s.8(1)(b)

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits saillants :

1. The licensee did not ensure that the most recent minutes of the Family Council meetings were posted in the home in a conspicuous and easily accessible location. It was observed that the home did have a location allocated for the posting of Family Council meetings minutes but that none were posted at the time of the inspection. The home staff member, who is assigned as the Family Council assistant confirmed that Family Council meeting minutes had not been posted in the home since August 2011. s.79(3)(o)

Issued on this 10th day of May, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs